Grantee Panel Presentation

Describing the process of assessing, planning, providing and monitoring comprehensive integrated services through a case illustration.

San Diego PBHCI Project
Cohort I - Western Region

Mental Health Systems, Inc (Fiduciary Agent)

Council of Community Clinics (Project Management)

Project Advisory Committee

County of San Diego, HHSA Behavioral Health Services

Demonstration Projects

Consumer Representation

South Pairing
Community Research Foundation – Imperial Beach Health Center

Consumer Representation

North Pairing
Mental Heatlh Systems – Neighborhood Healthcare

SD-PBHCI dedicated staff are out-stationed at the MH agency in each Pairing (Community Research Foundation and Mental Health Systems) including a Nurse Care Manager, Nurse Practitioner, Wellness Coordinator, Case Manager, and Data Collection staff.

Project Background

SD-PBHCI was the first cross system integration project in San Diego. The project was funded beginning September 30, 2009 and services were launched on February 1, 2010.

Enrollment

900 unduplicated program participants enrolled in the first 3 program years (10/1/2009-9/30/12)

1,050 projected to be enrolled by the end of the 4th year (9/30/13)

260 active program participants today

Services

12-month period
(10/1/2011-9/30/2012)

1,598 visits with a Nurse Care Manager

1,143 visits with a Primary Care Provider

1,917 wellness encounters delivered

Client Background

DEMOGRAPHICS

- San Diego County is roughly the size of the State of Connecticut (65 mi. North to South and 86 mi. East to West) – There are 43 miles between the SD-PBHCI North and South Pairing sites
- Target Population: Individuals with Serious Mental Illness (SMI), as defined by CA Welfare and Institutions Code Sec 5600.3
- 934 Unduplicated participants – 42%* Male, 58%* Female, .2%* Transgender
- 29%* Age 18-34, 50%* Age 35-54, 21%* Age 55>
- Large Latino Population in the South – 47.4%*
- 84%* Unemployed
- Larger Homeless Population in the North
- MH Needs/Trauma – We estimate clients that have a history of trauma is large; Info. difficult to obtain based on how we currently assess and client interpretation. Based on recent TIC Training provided by Cheryl Sharp, SD-PBHCI partners are looking at ways we can approach this subject differently with clients
- Substance Use/Tobacco

Initial engagement in the PBHCI service model

- Most clients enter BH Agency as walk-ins
- MH staff makes determination to refer client
- Warm Hand Off of Client to Nurse Care Manager
- Provide Overview of Program to Client
- Sign Client Release Form and give to MH Provider
- Complete NOMS
- Collect Clinic Registration Information

Assessment Process (con't)

- Register participant in PMS (IBHC or NHC)
- Conduct Initial Screening & Create Care Coordination Chart
- Schedule Fasting Lab Draw Date
- Enter Initial Screening Info. into Registry System
- Call Client to Remind about Appointment
- Draw Labs & Place Order Online with Lab Vendor

Assessment Process (con't)

- Schedule Follow-up Lab Appointment
- Receive/Review Lab Results
- Call Client and Remind of Appointment to review Lab Results
- Enter Labs into Registry as needed
- Review Results with Clients
- Determine if additional treatment is needed – If yes, complete Referral (North – NP; South – NCM))
- Complete Plan Form for all Clients

Assessment Process (con't)

- Engage in Wellness Programming
- Schedule and Conduct 3 mo. Follow-up Appointment
- Make Referral to Clinic if Medical Home and Send Results and Plan to MH and Clinic; N. Pairing – Schedule appointment with NP unless client has an established Medical Home
- If Existing Provider Send Referral Letter with Screening and Lab Results
- Make 6-month Follow-up Appointment if no Treatment needed
- Call Client to remind of appointment
- Conduct 6-Month Follow-up and Complete Assessment Form

Wellness Programming

The SD-PBHCI Project has continually adapted its wellness programming based on client feedback, and client participation in wellness activities continues to grow. SD-PBHCI Wellness Activities/Services include:

Core Wellness Programming

Peer Specialists work closely with the **Wellness Coordinators** and provide a leadership role in many of the activities that are included as part of the SD-PBHCI Core Wellness Programming including:

- Nutrition/Wellness Group Classes
- YMCA Exercise Sessions/Yoga
- Aquatics
- Stretch Fit
- Walking Groups
- Zumba
- Individual Wellness Appointments and Consultation with a Registered Dietician

Wellness Resource Packet

In an effort to sustain wellness practices beyond the scope of the program, a wellness resource packet has been developed for clients transitioning out of the MH agency. The packet includes:

- Individual Wellness Plan to outline wellness goals
- Free Community Wellness Resources

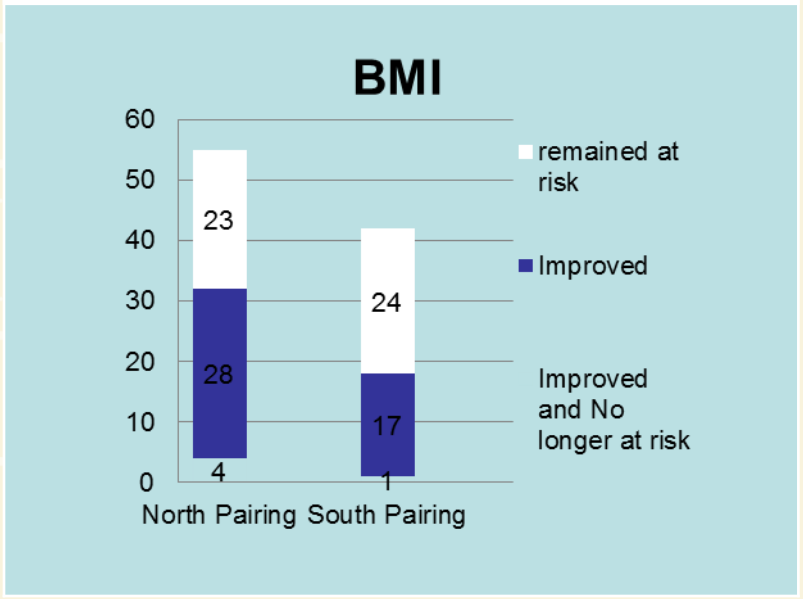
Monthly Wellness Field Trips

Designed to encourage healthy behaviors and develop social skills by taking participants to different local venues

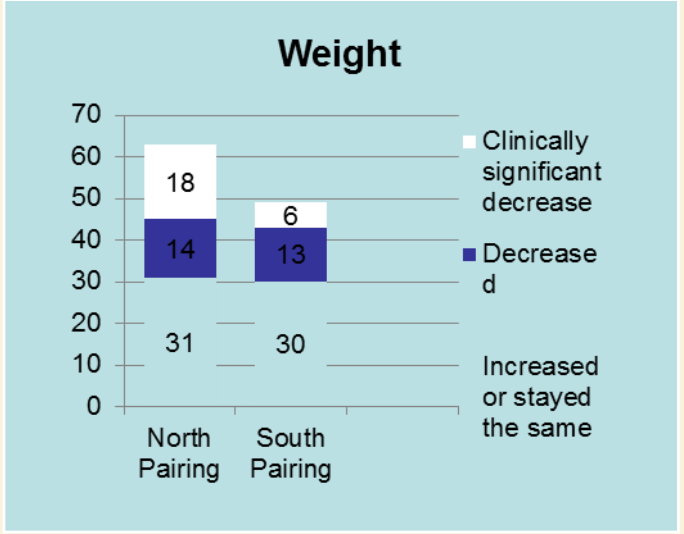
WHAM

Changes in Physical Health Indicators for a cohort of 113 Participants**

Changes in BMI for participants at risk at baseline n=97



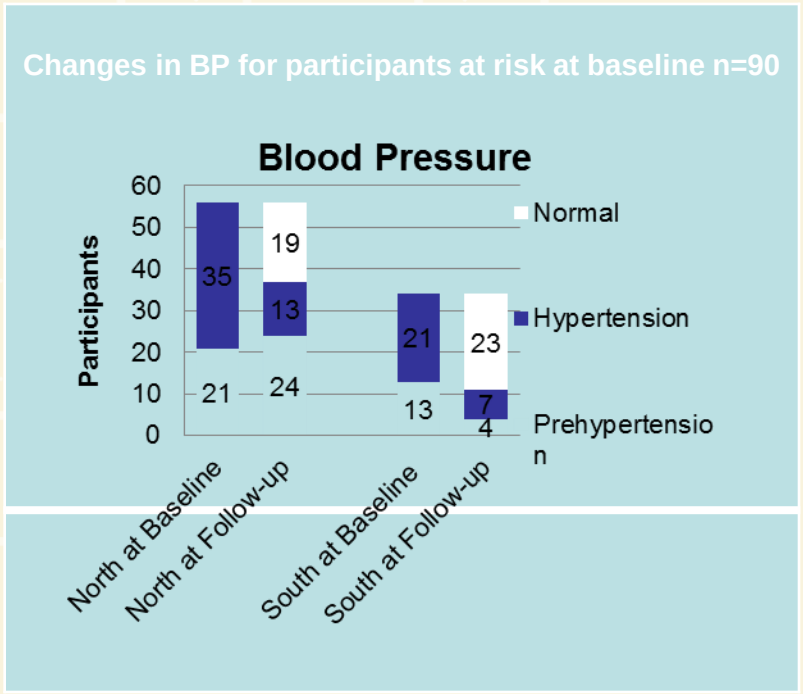
Changes in weight from baseline to follow-up n=112

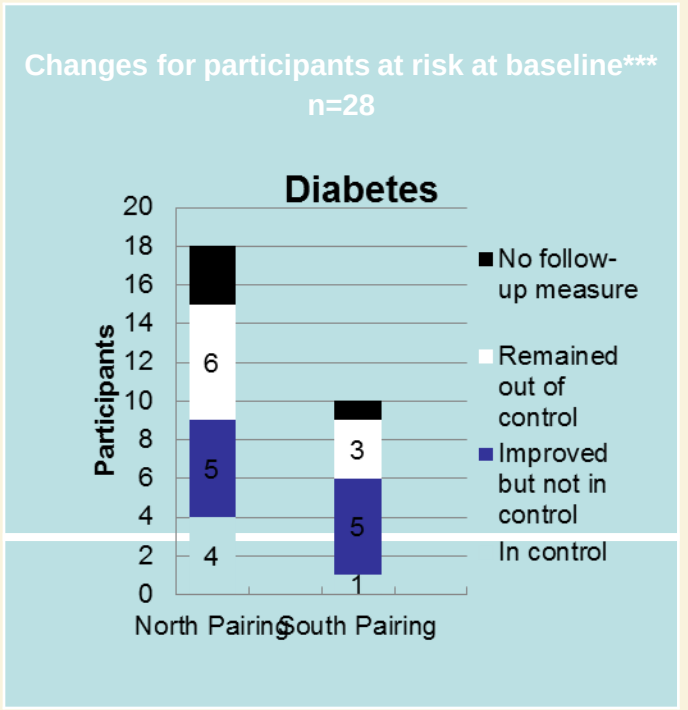


"At risk" is defined as overweight (BMI 25.0-29.9) or Obese (BMI ≥30)

***113 participants enrolled between Feb. and July 2010. Minimum enrollment of 15 months in project. Compares first recorded measure with last recorded measure.*

Changes in Physical Health Indicators for a cohort of 113 Participants**





"At Risk" defined as blood pressure above 120/80.

"At Risk" defined as A_1C>6.0 or glucose>110.

****A1C measured for North Pairing and Glucose measured for South Pairing.*

Progress Monitoring (H indicators and other health conditions)

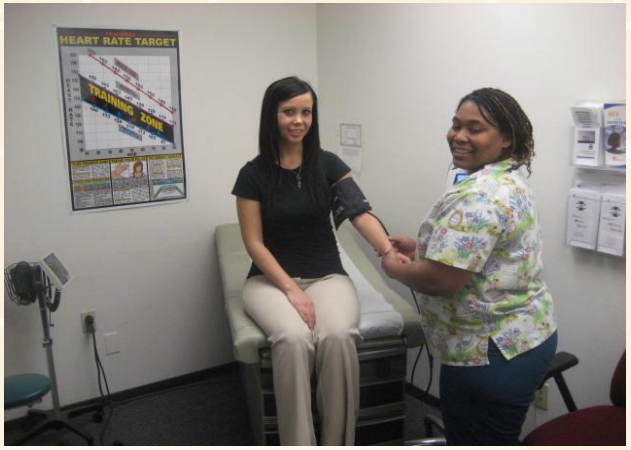
- How are H indicators/other conditions monitored?
  - Lab results reviewed within 24 hours; Follow-Up appointments
- By whom?
  - Nurse Care Manager, Nurse Practitioner, Clinic Medical Director, MH Clinicians, Wellness Coordinators
- How often?
  - Determined by patient need
- How is information accessed?
  - Lab Results are accessed on-line; Client charts; PMS
- How is information shared with client and the integrated care team?
  - Results are shared with the client at the Plan Appointment
  - Results are shared with PC and BH providers - Staff Meetings, Cross-Training of staff in PMS

Individualized Care Plan – Behavioral Health

- Frequency
  - Seen more often until stabilized
  - Ongoing every 2-3 months
- Provider(s)
  - At minimum, Psychiatrist/NP followed by RN/LVN
  - Client may be referred for counseling services – Individual and/or group sessions provided by MH Clinicians
- Focus and Frequency of Treatment
  - Dependent upon client need and level of functioning

Individualized Care Plan – Primary Care

- Frequency
  - Based on physical health status and lab results
- Provider(s)
  - Nurse Practitioner (North Pairing on-site), Medical Doctors, Nurse Care Managers
- Focus of service
  - Determined by patient need - Abnormal lab results, Elevated BP, Previous existing condition(s), etc.
  - Additional PC services – Dental Services, Vision Screenings, Mobile Mammography



Complete exam room built by FQHC at mental health agency

Loma Verde pool, site of aquatic classes

Stretch-Fit classes

Shadows of the walking group members

Year 4 – Focus on Sustainability

- Key Components of Sustainability identified by SD-PBHCI Agency Partner Executives
- Draft Sustainability Plan Developed
- Ongoing discussions at Pairing and Advisory Levels
- SD-PBHCI Agency participation in San Diego Integration Institute – Learning Communities